ACKNOWLEDGMENT OF REQUIREMENT TO
STAY HOME IF EXHIBITING COVID-19 SYMPTOMS

An employee who experiences fever and/or respiratory symptoms (coughing or shortness of breath) while home should not report to work**.** Instead, the employee should contact his or her medical provider or use telemedicine for further direction and the employee should report the work absence to the supervisor per City policy.

An employee who reports to work and has a fever of 100.4 degrees Fahrenheit or higher or who is experiencing coughing or shortness of breath will be sent home. The employee will be required to contact a doctor or use telemedicine to seek further direction.

An employee who was sent home or did not report to work due to a fever and/or respiratory symptoms can return to work when:

- He or she has had no fever for at least three (3) days without taking medication to reduce the fever during that time: AND
- Any respiratory symptoms (cough and shortness of breath) have improved for at least three (3) days; and
- At least ten (10) days have passed since the symptoms began.
- An employee may return to work earlier if a doctor confirms that the cause of an employee's fever or other symptoms is not COVID-19 and releases the employee to return to work in writing.

If an employee experiences other COVID-19 related symptoms, they should consult their medical provider or use telemedicine.

By signing this acknowledgment, I am intentionally communicating to the City of De Pere that I understand the above listed physical conditions are symptoms of COVID-19 and that by reporting to work for the City each day, I am not experiencing any of those symptoms. Further, I understand that if I begin to experience fever (100.4 degrees Fahrenheit or higher), coughing, or shortness of breath, I will not report to work, or, if I am already at work, I will tell my supervisor that I do not feel well, and communicate my symptoms to my health care provider. If I experience other COVID-19 related symptoms, I will contact my medical provider or use telemedicine.

_____   _____

Employee Signature   Date

_____   _____

Employee Name (printed)   Department